MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4840

CERTIFICATE OF DEATH

04828

1 (M)

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonesboro
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Reeder Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brunswick
d. STREET ADDRESS: 810 N. Maple Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1935-1

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Virginia — Last: Anderson

4. DATE OF DEATH: Month: 4 — Day: 22 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10-21-1879

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

I

13. FATHER'S NAME: Calvin Grove

14. MOTHER'S MAIDEN NAME: Kathleen Hankey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Albert L. Anderson, Brunswick, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 Days

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arterio-sclerosis — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fracture of left hip.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☒ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Slipped on Bathroom floor

20c. TIME OF INJURY Hour: 6 a.m. p.m. — Month, Day, Year: 3-27 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME

20f. (City or town): Brunswick — (County): Frederick — (State): Md

21. I certify that (I) (this hospital) attended the deceased from October, 1960 to April 22, 1961, that (I) (we) last saw the deceased alive on April 22 1961, and that death occured at 11:50 P.M, from the causes and on the date stated above.

22a. SIGNATURE: J Secondari M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 23 1961

22c. PHYSICIAN'S NAME (Type): JOSEPH SECONDARI

22d. ADDRESS: BOONSBORO MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-25-61

23c. NAME OF CEMETERY OR CREMATORY: Park Heights

23d. LOCATION (City, town or county) (State): Brunswick, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: B. Lee Fouke

ADDRESS: Brunswick, Maryland

25a. REC'D BY REGISTRAR DATE: APR 26 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4841 04829

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hr. 55 min

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport RFD #2 (Rural)

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital
d. STREET ADDRESS: (Rural) Williamsport Md RFD2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Gene — Middle: Lee — Last: Atha

4. DATE OF DEATH: Month: April — Day: 16 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 16 1961

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — Hours: 2 — Min.: 55
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: James Donald Atha

14. MOTHER'S MAIDEN NAME: Shirley Jean Shupp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. James D. Atha Williamsport Md RFD #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature birth 5 months
DUE TO (b): Pollyhydramnos
DUE TO (c):

7625

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/16 1961 to Same 19 , that (I) (we) last saw the deceased alive on 4/16 1961, and that death occurred at 10:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David R Brewer M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/19/61

22c. PHYSICIAN'S NAME (Type): David R. Brewer
22d. ADDRESS: Clear Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 18-61
23c. NAME OF CEMETERY OR CREMATORY: St. Pauls Cemetery
23d. LOCATION (City, town, or county) (State): Western Pike near Clearspring Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf
ADDRESS: Williamsport, Md

25a. REC'D BY REGISTRAR DATE APR 20 '61
25b. REGISTRAR'S SIGNATURE: Arthur S Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

2181192 X V 0

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4842 — 04830

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hr. 5 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Williamsport RFD #2
d. STREET ADDRESS: (Rural Williamsport Md. RFD 2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: Lee — Last: Atha

4. DATE OF DEATH: Month: April — Day: 16 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 16-61

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 1 — Min. 5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: James Donald Atha

14. MOTHER'S MAIDEN NAME: Shirley Jean Shupp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. James D Atha Williamsport Md RFD #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 762.5 — Premature Birth 5 Months
DUE TO (b): Polly hydramnos
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 16 1961 to Same 19___, that (I) (we) last saw the deceased alive on April 16 1961, and that death occurred on 5:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David R. Brewer M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/17/61

22c. PHYSICIAN'S NAME (Type): David R. Brewer

22d. ADDRESS: Clear Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 18-61

23c. NAME OF CEMETERY OR CREMATORY: St. Pauls Cemetery

23d. LOCATION (City, town, or county) (State): Western Pike Near Clearspring Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Albert L Leaf Williamsport, Md

25a. REC'D BY REGISTRAR DATE: APR 20 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruns

2281193XVO

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4843 04831

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonesboro
c. LENGTH OF STAY IN 1b: 19 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Fahney-Keedy Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 03
d. STREET ADDRESS: Summet Ave. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First Mary — Middle Elizabeth — Last Baechtel

4. DATE OF DEATH: Month April — Day 4 — Year 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 28, 1873
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Hagerstown Wash. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Edward Baechtel
14. MOTHER'S MAIDEN NAME: Sarah Jane McDowell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Fahney-Keedy Home Records, Boonesboro, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
450.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 2, 1960, to April 4, 1961, that (I) (we) last saw the deceased alive on April 4 1961, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: G.W. LeVan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/5/61
22c. PHYSICIAN'S NAME (Type): G. W. LeVan
22d. ADDRESS: Boonsboro, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/7/61
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown, Maryland
25a. REC'D BY REGISTRAR DATE: APR 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4844 302 04832

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 106 So Locust St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHY Middle LOU Last BAKER

4. DATE OF DEATH: Month April Day 7 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 2 1961

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days 5
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Durell Baker

14. MOTHER'S MAIDEN NAME: Delores M. Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Durell Baker
Address: 106 So Locust St Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CMO PREMATURE BIRTH LBD 1'14"
DUE TO (b): PULMONARY HYALINE MEMBRANE
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: (a) 4/9/61 (b) 12 HRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 773.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 4/7/61 19 to 4/7/61 19, thot (I) (we) last saw the deceased alive on 4/7/61 19, and that death occurred at 6:50 PM from the causes and on the date stated above.

22a. SIGNATURE: Ralph F. Young M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/8/61

22c. PHYSICIAN'S NAME (Type): Ralph F: Young M.D

22d. ADDRESS: Williamsport Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/8/61
23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 12 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2081336XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4845 — 04833

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BENEVOLA - RURAL
c. LENGTH OF STAY IN 1b: 54 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BOONSBORO MD. R.1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BENEVOLA - RURAL
d. STREET ADDRESS: 1 BOONSBORO MD. R.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SUSIE — Middle: C — Last: BAKER

4. DATE OF DEATH: Month: APRIL - Day: 1 - Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUGUST - 11 - 1878

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: 7 Days: 20
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): KEEDYSVILLE WASH. Co. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN H. JONES

14. MOTHER'S MAIDEN NAME: MARY E. McNAMEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: MRS. AUSTIN A. ROWE BOONSBORO MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hypertensive Cardio-Vasc. Disease	Aug 23-1957
DUE TO (b)	Cerebral Thrombosis	Jan 6-1961
DUE TO (c)	Arterio-Sclerosis	

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 23 1957 to April 1 1961, that (I) (we) last saw the deceased alive on April 1 1961, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Sidney Novenstein M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-3-61

22c. PHYSICIAN'S NAME (Type): SIDNEY NOVENSTEIN

22d. ADDRESS: FUNKSTOWN MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: APRIL-4-1961

23c. NAME OF CEMETERY OR CREMATORY: MANOR CEMETERY

23d. LOCATION (City, town, or county) (State): NEAR TILGHMANTOWN WASH. Co. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast ADDRESS: BOONSBORO MD

25a. REC'D BY REGISTRAR DATE: APR 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kreps

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4846

CERTIFICATE OF DEATH

04834

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Jackson Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d. STREET ADDRESS: 136 S. Broad St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Grace; Middle Haugh; Last Barr

4. DATE OF DEATH: Month April; Day 25; Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 21, 1876
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cornelius Haugh
14. MOTHER'S MAIDEN NAME: Catherine Birely

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: - - -
17. INFORMANT: Miss Catherine Culbertson Address: Waynesboro, Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile Psychosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 19__ to ____ 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at 2:15 PM from the causes and on the date stated above.

22a. SIGNATURE: Paul Harrison M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/25/61
22c. PHYSICIAN'S NAME (Type): Paul Harrison
22d. ADDRESS: 318 N. Potomac St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/28/61
23c. NAME OF CEMETERY OR CREMATORY: Green Hill
23d. LOCATION (City, town, or county) (State): Waynesboro, Franklin, Penna.

24. FUNERAL DIRECTOR'S SIGNATURE: Walter G. Shoe ADDRESS: Waynesboro, Penna.
25a. REC'D BY REGISTRAR DATE: APR 27 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kline

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4847

CERTIFICATE OF DEATH

04835

M

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 7yrs 11 mos.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Williamsport
d. STREET ADDRESS: 143 N. Artizan St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Elsie — Middle: VIRGINIA — Last: Beard

4. DATE OF DEATH: Month: April — Day: 2 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: January 22, 1867
9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months: 2 Days: 10
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Williamsport Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: Martin VAN Buren Harsh
14. MOTHER'S MAIDEN NAME: Emily Catherine Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: I, Gaver Beard — Address: Williamsport, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Generalized Atherosclerosis
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cacheria

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) this hospital) attended the deceased from Aug 19[illegible] to April 2 1961, that (I) (we) last saw the deceased alive on April 2 1961, and that death occurred at 4 P.M., from the causes and on the date stated above.

22a. SIGNATURE: M E Byrkit M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-2-61
22c. PHYSICIAN'S NAME (Type): M E Byrkit
22d. ADDRESS: Williamsport Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/4/61
23c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
23d. LOCATION (City, town, or county) (State): Williamsport, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf — ADDRESS: Williamsport, Md.
25a. REC'D BY REGISTRAR DATE: APR 4 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Mauck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4843 04836

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Md. State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg
d. STREET ADDRESS: 109 S. Hall Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Amelia Vera Middle Last Benner

4. DATE OF DEATH: Month April Day 10 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 24 1907
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months 11 Days 16
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Public School
11. BIRTHPLACE (State or foreign country): Sharpsburg Md.
12. CITIZEN OF WHAT COUNTRY?: U. S. A

13. FATHER'S NAME: George W. Mongan
14. MOTHER'S MAIDEN NAME: Helen M. Penner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217 18 8975
17. INFORMANT: Mr. Ray G. Benner Address: 109 S. Hall Street Sharpsburg Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	general carcinomatosis	3 mos.
DUE TO		
175.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	carcinoma of the ovary	5 mos.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 17, 1961, to April 10, 1961, that (I) (we) last saw the deceased alive on April 10, 1961, and that death occurred at 10:25 PM, from the causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: April 10, 1961
22c. PHYSICIAN'S NAME (Type): Victor L. Ramos, M.D.
22d. ADDRESS: Western Maryland State Hospital Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 13-61
23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
23d. LOCATION (City, town, or county) (State): Sharpsburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Kopp
ADDRESS: Williamsport, Md
25a. REC'D BY REGISTRAR DATE APR 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kruna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4849 Item 9 Film G284 4/14/61 iwk

Reg. Dist. No. 04837

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clearspring R F D
c. LENGTH OF STAY IN 1b: ½ Hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Willsons

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Clearspring R # 2
d. STREET ADDRESS: St Pauls
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ROGER Middle LE ROY Last BILLMAN

4. DATE OF DEATH: Month April Day 5 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 20 1908

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor B.& O R.R.

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Billman

14. MOTHER'S MAIDEN NAME: Ida A. McCarty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: 160-16-7564

17. INFORMANT: Address: Mrs Rose S. Billman Clear Spring R # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): St Pauls Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (b): 422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: N. W Dutto Jr M.D.
EXAMINER'S NAME (Type): N W DUTTO JR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4/6/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/8/61
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: APR 11 '61

24b. REGISTRAR'S SIGNATURE: Christine S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4850 04838

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNA
b. COUNTY: FRANKLIN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): STATE LINE
d. STREET ADDRESS: STATE LINE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75X-3

081

3. NAME OF DECEASED (Type or print): First FLOYD Middle N. Last BINKLEY

4. DATE OF DEATH: Month APRIL Day 18 Year 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/7/1892

9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Franklin Co., Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Franklin Binkley

14. MOTHER'S MAIDEN NAME: Emma Brumbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NK (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 180-10-8657

17. INFORMANT: Mrs. Grace Meyers — Address: State Line, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia + Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: about 2 wks

DUE TO (b): Hypertensive Cardiovascular disease — 10 years(?)

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-25 1952 to 4-18 1961, that (I) (we) last saw the deceased alive on 4-18 1961, and that death occurred at 10:07 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John H Hornbaker M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-20-61

22c. PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D.

22d. ADDRESS: 154 West Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): B.

23b. DATE THEREOF: 4/21/61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City, town, or county) (State): Greencastle, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: A.E. Minnich — ADDRESS: Greencastle, Pa.

25a. REC'D BY REGISTRAR DATE: APR 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4851 — 04839

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 707 Salem Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 707 Salem Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle JANE — Last BLACK

4. DATE OF DEATH: Month April — Day 27 — Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 22, 1887

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): near Luray, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Price

14. MOTHER'S MAIDEN NAME: Carolyn Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. B. Franklin Young — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: Days
420.0
DUE TO (b): Arteriosclerotic heart disease — 3 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Generalized arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 16, 1961, to April 27, 1961, that (I) (we) last saw the deceased alive on Apr 26 1961, and that death occured at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John C. Stauffer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): John C. Stauffer M. D.

22d. ADDRESS: Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/30/1961

23c. NAME OF CEMETERY OR CREMATORY: Keesletown Cemetery

23d. LOCATION (City, town or county) (State): Keesletown Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Suter - Rouzer Funeral Home — R. Franklin Rouzer

ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 1 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kreas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4852 **CERTIFICATE OF DEATH** 303 04840

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 12 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 318 McDowell Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 318 McDowell Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAROLD Middle EVERINGTON Last BOWEN

4. DATE OF DEATH: Month April Day 6 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 23 1902

9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fairchild Air Craft

10b. KIND OF BUSINESS OR INDUSTRY: Elec Inspector

11. BIRTHPLACE (State or foreign country): Wellsboro Tioga Co Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John R. Bowen

14. MOTHER'S MAIDEN NAME: Mary E. Rumsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 226-05-9538

17. INFORMANT: Address: Mrs Mabel S. Bowen 318 McDowell Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Hagerstown Md.

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1 day.

DUE TO (b): Chronic Pulmonary Bronchitis — 3 years

DUE TO (c): Emphysema

502.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 19__ to 6 Apr 19 61, that (I) (we) last saw the deceased alive on 6 Apr 19 61, and that death occurred at 4 P.M. from the causes and on the date stated above.

22a. SIGNATURE: J D Wilson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/7/61

22c. PHYSICIAN'S NAME (Type): J. D. Wilson, M.D.

22d. ADDRESS: 135 N. Potomac St, Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/8/61

23c. NAME OF CEMETERY OR CREMATORY: Verona Cemetery

23d. LOCATION (City, town, or county) (State): Verona Augusta Co Va

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 11 '61

25b. REGISTRAR'S SIGNATURE: Charles L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4853 Item 8 Film G264 4/14/61 iwk 04841

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington Cty. Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): Maugansville
d. STREET ADDRESS: North St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Emory — Middle: Eugene — Last: Boyer

4. **DATE OF DEATH**: Month: Apr. — Day: 9 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January / June 28, 1929

9. AGE (In years last birthday): 32 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unable to work

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (State or foreign country): Maugansville, Wash. Cty.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pearre Boyer

14. MOTHER'S MAIDEN NAME: Anna Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. **INFORMANT** Address: Mrs. Anna S. Boyer, Maugansville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
442X
Conditions, if any, which gove rise to immediate cause (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Mentally retarded since birth.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 5, 1961, to April 9, 1961, that (I) (we) last saw the deceased alive on April 9, 1961, and that death occurred at 1:20 A M, from the causes and on the date stated above.

22a. SIGNATURE: E. W. Ditto M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4-10-61

22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr.

22d. ADDRESS: 215 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/11/61

23c. NAME OF CEMETERY OR CREMATORY: Dunkard Cemetery

23d. LOCATION (City, town, or county) (State): Broadfording, Wash. Cty., Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 12 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4854 04842

M

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Penna. b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Greencastle
d. STREET ADDRESS Greencastle RD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75X-3

X

3. NAME OF DECEASED (Type or print) First W. Middle MAYNARD Last BROWN

4. DATE OF DEATH Month April Day 25 Year 1961

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Dec 2, 1880

9. AGE (In years last birthday) 80 yrs.

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper & Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Fulton Co., Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME David S. Brown

14. MOTHER'S MAIDEN NAME Catherine Ashwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 220-18-0956

17. INFORMANT Katherine Gordon Address 274 Frederick St. Hagerstown, md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3 hours
DUE TO
(b) Adenocarcinoma Stomach — 3 years
DUE TO
(c)

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/14/61 19__ to 4/25/61 19__, that (I) (we) last saw the deceased alive on 4/24/61 19__, and that death occurred at 4:30 A.M. from the causes and on the date stated above.

1

22a. SIGNATURE Robert V.h Campbell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 4/26/61

22c. PHYSICIAN'S NAME (Type) Robert V.h. Campbell

22d. ADDRESS Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify) B.

23b. DATE THEREOF 4/27/61

23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cem.

23d. LOCATION (City, town, or county) (State) Cooleytown, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE A. E. Mummert ADDRESS Greencastle, Pa.

25a. REC'D BY REGISTRAR DATE APR 28 '61

25b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4855

CERTIFICATE OF DEATH

04843

1 (M)

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 335 N. Potomac Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 335 N. Potomac Street
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAMUEL — Middle CARLETON — Last CLOPPER

4. DATE OF DEATH: Month April — Day 19 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 13, 1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bookkeeper

10b. KIND OF BUSINESS OR INDUSTRY: Plumber

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William O. Clopper

14. MOTHER'S MAIDEN NAME: Susam Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-09-1751

17. INFORMANT — Address: Dr. Evelyn C. Luke Hagerstown, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — 4 Days
DUE TO (b): Ca of Prostate — Oct 1956
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. 177X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: None 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None

20f. (City or town) — (County) — (State)

21. I certify that (I) (this hospital) attended the deceased from April 17 '61, 19..., to April 19, 19 61, that (I) (we) last saw the deceased alive on April 19 19 61, and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: John D. Turco M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — Family Dr. out of town

22b. DATE SIGNED: 4-19-61

22c. PHYSICIAN'S NAME (Type): Dr. John D. Turco

22d. ADDRESS: 302 N. Potomac St-Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/21/ 1961

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Suter - Rouzer Funeral Home

ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 26 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4856

CERTIFICATE OF DEATH

04844

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Hancock Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institutian: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn): Little Orleans
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alberta — Middle: Tacy — Last: Creek

4. DATE OF DEATH: Month: 4 — Day: 15 — Year: 19-61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/11/1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Matyland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alfred Creek

14. MOTHER'S MAIDEN NAME: Rebecca Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 215-14-6042A

17. INFORMANT: Scott M. Mann — Address: Little Orleans Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Cardio Vascular
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
DUE TO (c): Arterio Sclerotic disease

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 3/28 19 58 to 4/14 19 61, that (I) (we) lost sow the deceased olive on 4/15 19 61, ond thot deoth occurred ot p.m., from the couses ond on the dote stoted above.

22a. SIGNATURE: L M Shaffer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): L. M. Shaffer

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/19/61

23c. NAME OF CEMETERY OR CREMATORY: Piney Plains Methodist

23d. LOCATION (City, town, or county) (State): Little Orleans Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Howard F Gore — ADDRESS: Hancock md

25a. REC'D BY REGISTRAR DATE: APR 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4857

CERTIFICATE OF DEATH

04845

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 2 weeks
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1708 Homewood Rd.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d. STREET ADDRESS: 1708 Homewood Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Emma — Middle: Mae — Last: Crilly

4. **DATE OF DEATH**: Month: April — Day: 23 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 6 1895

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months 10 Days 16 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Houseiwfe

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: George Reed

14. MOTHER'S MAIDEN NAME: Virginia (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Roy K Crilly — Address: 1708 Homewood Rd. Md Hagerstown

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CORONARY ARTERY OCCLUSION, WITH MYOCARDIAL INFACRTION	5 minutes
DUE TO (b)	CORONARY ARTERY ATHEROSCLEROSIS	UNKNOWN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	DIABETES MELLITUS	10 years

260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive arteriosclerotic Heart disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December 8, 1950, to April 23, 1961, that (I) (we) last saw the deceased alive on April 22 1961, and that death occured at 9:35PM from the causes and on the date stated above.

22a. SIGNATURE: Archie Robert Cohen M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED 4/24/61

22c. PHYSICIAN'S NAME (Type): Archie Robert Cohen, M.D.

22d. ADDRESS: Clear Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 26-61

23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery

23d. LOCATION (City, town or county) (State): Williamsport Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Allen L Leaf — ADDRESS: Williamsport, Md

25a. REC'D BY REGISTRAR DATE APR 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4853 Reg. Dist. No. 04846

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 215 E. Franklin St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 215 E. Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard — Middle: William — Last: Easton

4. DATE OF DEATH: Month: April — Day: 7, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 11, 1884

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Pangborn Corp.

11. BIRTHPLACE (State or foreign country): Greencastle, Penna.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Upton Easton

14. MOTHER'S MAIDEN NAME: Rebecca Lilly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-6616

17. INFORMANT — Address: Mrs. H. W. Easton 215 E. Franklin St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs
420.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto Jr. M.D.
EXAMINER'S NAME (Type): Dr. E. W. Ditto Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4/6/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/10/61
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel
ADDRESS: Hagerstown, Md.
Wm. G. Mont

24a. REC'D BY REGISTRAR DATE: APR 10 '61
24b. REGISTRAR'S SIGNATURE: Caroline S. Fraser

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4859

CERTIFICATE OF DEATH

04847

1 M

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4½ mos.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Martin Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Pa. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chambersburg
d. STREET ADDRESS: 202 S. Second St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75x-3

090

3. NAME OF DECEASED (Type or print): First: DELLA — Middle: M. — Last: ETCHBERGER

4. DATE OF DEATH: Month: April — Day: 30 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 18, 1883

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Chambersburg, Pa.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David Carr

14. MOTHER'S MAIDEN NAME: Annie Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: -

17. INFORMANT: J.E. Etchberger — Address: 244 S. 6th. St. Chambersburg, Pa.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO (b): Cerebral Hemorrhage — Recent

DUE TO (c): Generalized arteriosclerosis — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-10-, 1961, to 4-30, 1961, that (I) (we) last saw the deceased alive on 4-29, 1961, and that death occured at 9 AM, from the causes and on the date stated above.

22e. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): [illegible]

22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/2/61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Grove Cem.

23d. LOCATION (City, town or county) (State): Chambersburg, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert B. Sellers — ADDRESS: 297 Phila. Ave. Chambersburg, Pa.

25a. REC'D BY REGISTRAR DATE: MAY 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4860

CERTIFICATE OF DEATH

04848

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
   c. LENGTH OF STAY IN 1b: 3wks.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Williamsport Sanitarium

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Penna — b. COUNTY: Adams
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairfield, Route 1 (Rural)
   d. STREET ADDRESS: 75X-3 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Hagel — Middle: Amanda — Last: Eyler

4. **DATE OF DEATH**: Month: April — Day: 15 — Year: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 9, 1895

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Sewing Factory

11. BIRTHPLACE (County & State, or foreign country): Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Kipe

14. MOTHER'S MAIDEN NAME: Nettie Harbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-05-9352

17. INFORMANT — Address: Robert J. Kipe, Fairfield Pa. R.D#1

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3-7 days
350X
DUE TO (b): Parkinsons Disease — 5-10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 Mar 19 52 to April 15, 1961, that (I) (~~we~~) last saw the deceased alive on 13 April 19 62, and that death occured at 5:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Harry Youngs M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4-17-61

22c. PHYSICIAN'S NAME (Type): HARRY H. YOUNGSTER — 22d. ADDRESS: Blue Ridge Summit, Pa

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: April 18, 1961 — 23c. NAME OF CEMETERY OR CREMATORY: St. Jacobs Reformed — 23d. LOCATION (City, town or county) (State): Fairfield, R.D.#1, Liberty Twp. Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: C. E. Wilson — ADDRESS: Fairfield, Pa. — 25a. REC'D BY REGISTRAR DATE: APR 19 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

C. E. Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4861

CERTIFICATE OF DEATH

04849

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 48 Years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 146 South Locust Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 146 South Locust Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELMER Middle DAVID Last FLORY

4. DATE OF DEATH: Month April Day 8 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 30, 1886

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Fairchild Aircraft, Waynesboro, Franklin Co.

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Adam Flory

14. MOTHER'S MAIDEN NAME: Elizabeth Hunsberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---------

16. SOCIAL SECURITY NO.: 214-09-4950

17. INFORMANT: Mrs. Mary P. Flory
Address: 146 S. Locust St. Hagerstown Wash. Co. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion with Infarction — INTERVAL BETWEEN ONSET AND DEATH: Min
420.1
DUE TO
(b): coronary Ischemia — 5 days
DUE TO
(c): Coronary Atherosclerosis — yrs.

Conditians, if any, which gave rise to immediate couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 1957 to April 8, 1961, that (I) (we) last saw the deceased alive on April 6 19 61 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Louis G. Graff M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Louis G. Graff, M.D.
22d. ADDRESS: 119 E. Antietam St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/11/61
23c. NAME OF CEMETERY OR CREMATORY: Shiloh E.U.B. Cemetery
23d. LOCATION (City, town, or county) (State): Security Wash Co Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE APR 12 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4862 04850

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Memorial Conv. Hospital
e. STREET ADDRESS RD3 Greencastle, Pa.

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Penna. b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Greencastle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Frederick Middle Speck Last FOX

4. DATE OF DEATH Month April Day 11 Year 1961

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 3/30/1881

9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter —

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Franklin Co., Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob Fox

14. MOTHER'S MAIDEN NAME Lillie Speck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 204-01-3157

17. INFORMANT Galen Fox - RD3 Address Greencastle, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage.
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH 6 Mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sep. 30, 1960, to April 11, 1961, that (I) (we) last saw the deceased alive on 4/8 1961, and that death occurred at 2154 M. from the causes and on the date stated above.

22a. SIGNATURE David R. Hess M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) David R Hess

22d. ADDRESS Shady Grove, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 4/14/61

23c. NAME OF CEMETERY OR CREMATORY Prices Cem.

23d. LOCATION (City, town, or county) near Waynesboro, Pa. (State)

24. FUNERAL DIRECTOR'S SIGNATURE A. E. Mummert ADDRESS Greencastle, Pa.

25a. REC'D BY REGISTRAR DATE APR 12 '61

25b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4863 Reg. Dist. No. 14851

1. PLACE OF DEATH
a. COUNTY: WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL SHANKTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NONE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL SHANKTOWN
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First RALPH Middle RAYMOND Last GEHR
4. DATE OF DEATH: Month APRIL Day 20 Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MARCH 14, 1880
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months 1 Days 6
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (State or foreign country): INDIAN SPRINGS, MD.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: DANIEL GEHR
14. MOTHER'S MAIDEN NAME: ELLA STEELE GEHR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: RALPH N. GEHR Address: BIG POOL, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	Instant
420.0 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	Arteriosclerotic Heart Disease	5 years
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. W. Ditto M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED: 4-21-61
EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: APRIL 23, 1961
22c. NAME OF CEMETERY OR CREMATORY: SHANKTOWN CEMETERY
22d. LOCATION (City, town, or county) (State): WASHINGTON CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John F Clark ADDRESS: CLEAR SPRING, MD.
24a. REC'D BY REGISTRAR DATE: APR 26 61
24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4864 — 14852

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: JACKSON CONVALESCENT HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND. b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BOONSBORO
d. STREET ADDRESS: 1 POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAVID. Middle GARFIELD Last GILBERT
4. DATE OF DEATH: Month APRIL Day 25. Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV. 13. 1881
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months 5 Days 12
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: GENERAL STORE
11. BIRTHPLACE (State or foreign country): BOONSBORO WASH. Co. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE W. GILBERT
14. MOTHER'S MAIDEN NAME: KATE LAKIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Address: MRS. LLOYD THOMPSON BOONSBORO MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis — Indefinite
DUE TO (c):

332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I/this hospital) attended the deceased from April 24 1961 to April 25 1961, that (I/we) last saw the deceased alive on April 24 1961, and that death occurred at 1:10 A. M., from the causes and on the date stated above.

22a. SIGNATURE: B. B. Kneisley M.D.
ATTENDING PHYS. X ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/26/61
22c. PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.
22d. ADDRESS: 148 West Washington Street Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: APRIL-27-1961
23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
23d. LOCATION (City, town, or county) (State): BOONSBORO WASH. Co. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Rast
ADDRESS: BOONSBORO MD.
25a. REC'D BY REGISTRAR DATE: MAY 1 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraas

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4865

CERTIFICATE OF DEATH

04853

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 Yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 106 North Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 106 North Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH — Middle MAY — Lost GREEK

4. DATE OF DEATH: Month April — Day 23 — Year 19 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 23 1875

9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Seward Westmorland Co Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James J. Rogers

14. MOTHER'S MAIDEN NAME: Annie Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Marie G. Shields — Address: 106 North Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic heart disease — 9 yrs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1946, 19___, to 4.23.61, 19___, that (I) (we) last saw the deceased alive on 4.19.61 19___, and that death occurred at 7.00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: S. Earl Young M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4.24.61

22c. PHYSICIAN'S NAME (Type): S. Earl Young M.D.

22d. ADDRESS: 148 N. Potomac St., Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/26/61

23c. NAME OF CEMETERY OR CREMATORY: Brush Creek Cemetery

23d. LOCATION (City, town, or county) (State): Manor Westmorland Co Pa.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown M.d

25a. REC'D BY REGISTRAR DATE: APR 25 '61

25b. REGISTRAR'S SIGNATURE: Cinthya L. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4866

CERTIFICATE OF DEATH

Reg. Dist. No. 04854

M

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Farhney-Keedy Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodlawn
d. STREET ADDRESS: 6419 Windsor Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

03 X-2

090

3. NAME OF DECEASED (Type or print): First Effie — Middle J. — Last Grossnickle

4. DATE OF DEATH: Month April — Day 24, — Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 1, 1877
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Carroll CO., Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

I

13. FATHER'S NAME: David Cover
14. MOTHER'S MAIDEN NAME: Laura J. Lindsay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Joshna H. Armacost, Mt. Wilson, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia
INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
493
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fractured hip

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fall
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year: May 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Woodlawn, Baltimore, Md.

21. I certify that I attended the deceased from Apr. 21, 1961, to Apr. 24, 1961, that I last saw the deceased alive on Apr. 24, 1961, and that death occurred at 5:10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Kneisley M.D.
ADDRESS (Street, city or town, state): 148 West Washington St.
DATE SIGNED: 4/25/61
PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.
Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-28-1961
22c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery
22d. LOCATION (City, town, or county) (State): Carroll Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C. M. WALTZ, WINFIELD, MARYLAND
24a. REC'D BY REGISTRAR — DATE: APR 27 '61
24b. REGISTRAR'S SIGNATURE: Clarence L. Kimble

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4867

CERTIFICATE OF DEATH

04855

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Jackson Convelascent Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 81 S. Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Bessie — Middle: M. — Last: Grove

4. **DATE OF DEATH**: Month: April — Day: 5 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 31, 1876

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months: 0 — Days: 5 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): Sharpsburg, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob C. Grove

14. MOTHER'S MAIDEN NAME: Elizabeth Mumma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. **INFORMANT** — Address: Mr. Lloyd S. Grove — Norfolk, Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e): Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Inanition — 4 mo.

DUE TO (c): Arteriosclerosis - Gen. — 4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from ..... 1956 to March 5, 1961, that (I) (~~we~~) last saw the deceased alive on March 5 1961, and that death occured at 6 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Lloyd A. Hoffman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/5/61

22c. PHYSICIAN'S NAME (Type): Lloyd A. Hoffman

22d. ADDRESS: 214 N. Pot. St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 7, 1961

23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

23d. LOCATION (City, town or county) (State): Sharpsburg, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Albert K Leaf — ADDRESS: Williamsport, Md

25a. REC'D BY REGISTRAR DATE: APR 10 '61

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4863

CERTIFICATE OF DEATH

04856

1 (M) (I)

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural-Hagerstown
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1843 Virginia Ave.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Hagerstown
d. STREET ADDRESS: 1843 Virginia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Emma	Gertrude	Harsh	April	2	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Nov. 25, 1880	80 yrs.	4	7		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Hagerstown, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Andrew Marr	Emma Rose Wallick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	Miss Emma C. Harsh	1843 Virginia Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 420.1 — DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b): — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/2/61, 19..... to 4/2/61, 19....., that (I) (we) last saw the deceased alive on 4/2/61 19....., and that death occured at 11:50PM, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Ralph F. Young			4/3/61

22c. PHYSICIAN'S NAME (Type): Ralph F. Young M.D. — 22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	April 5, 1961	Greenlawn Cemetery	Williamsport, Md.

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE APR 4 '61	25b. REGISTRAR'S SIGNATURE
Albert L. Leap	Williamsport, Md.		Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4869

CERTIFICATE OF DEATH

04857

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
   c. LENGTH OF STAY IN 1b: 18 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Williamsport Sanitarium

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Pennsylvania — b. COUNTY: Franklin
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
   d. STREET ADDRESS: 24 N. Grant St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Roy — Middle: C. — Last: Haugh

4. **DATE OF DEATH**: Month: April — Day: 14 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 4, 1883

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Frederick Co, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cornelius Haugh

14. MOTHER'S MAIDEN NAME: Mary Bierly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 173-03-1833

17. **INFORMANT** — Address: Mrs. Mary K. Haugh, 24 N. Grant St., Waynesboro, Penna.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Respiratory collapse — INTERVAL BETWEEN ONSET AND DEATH: 45 min
DUE TO (b): Diffuse metastatic Carcinoma
DUE TO (c): Prostatic Carcinoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY ~~Month, Day~~, Year — Hour a.m. / p.m. — 19

20d. INJURY ~~OCCURRED~~ While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Apr. 12, 1961 to Apr. 14, 1961, that (I) (we) last saw the deceased alive on April 12, 1961, and that death occured at 12 P.M., from the causes and on the date stated above.

22a. SIGNATURE: M.E. Byrkit M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4-14-61

22c. PHYSICIAN'S NAME (Type): M.E. Byrkit

22d. ADDRESS: Williamsport Md

23a. BURIAL, CREMATION, REMOVAL (Spacify): Burial

23b. DATE THEREOF: 4/18/1961

23c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery

23d. LOCATION (City, town or county) (State): Waynesboro Penna.

24 FUNERAL DIRECTOR'S SIGNATURE: S. Marlin Poe — ADDRESS: Waynesboro, Penna.

25a. REC'D BY REGISTRAR — DATE: APR 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4870

04858

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 157 E. Antietam St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William; Middle: Oliver; Last: Heil

4. DATE OF DEATH: Month: April; Day: 9; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Unknown 1882

9. AGE (In years lost birthday): About 79

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Drug Store

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Heil

14. MOTHER'S MAIDEN NAME: Carrie Irvin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-2660

17. INFORMANT: Clifton M. Bachtell — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO (b): Hypertensive Vasc. disease — 2 yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

330 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this~~ hospital) attended the deceased from 1955, 19__, to April 9, 1961, that (I) (WE) last saw the deceased alive an April 9 1961, and that death occurred at 4 P M, from the causes and an the date stated abave.

22a. SIGNATURE: Lloyd A. Hoffman M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/10/61

22c. PHYSICIAN'S NAME (Type): Lloyd A. HOFFMAN

22d. ADDRESS: 214 N. Potomac St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-12-61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 12 '61

25b. REGISTRAR'S SIGNATURE: Emma L. Frantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4871

CERTIFICATE OF DEATH

Reg. Dist. No. 04859

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MARTIN MANOR REST HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNA. — b. COUNTY: FRANKLIN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - MERCERSBURG
d. STREET ADDRESS: R. #3 75X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First: BEULAH — Middle: M. — Last: HILL

4. DATE OF DEATH: Month: April — Day: 21, — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/19/1892

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MERCERSBURG, PA., R.D.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DANIEL KISER

14. MOTHER'S MAIDEN NAME: ADA STRAITIFF

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: FRANK L. HILL, MERCERSBURG, PA, R.3

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Few

1742
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis of Lung + Lungs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/30/61, 19____, to 4/21/61, 19____, that I last saw the deceased alive on 4-20-61, 19____, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 315 W Washington — DATE SIGNED: 4/24/61

PHYSICIAN'S NAME (Type): DR E W [illegible] D — Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4/24/61

22c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEM.

22d. LOCATION (City, town, or county) (State): MERCERSBURG PA.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: MERCERSBURG, PA.

24a. REC'D BY REGISTRAR DATE: APR 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,11,12,13 & 14 information from birth certif. 4/28/61 iwk

4872

CERTIFICATE OF DEATH

Reg. Dist. No. 04860

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 03
d. STREET ADDRESS: 47 Valley Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HUBERT WAYNE Middle Last HOFF

4. DATE OF DEATH: Month APR. Day 19 Year 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr. 19, 1961
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours 3 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oren Dale Hoff
14. MOTHER'S MAIDEN NAME: Laura Z. Frazee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immature Birth, — INTERVAL BETWEEN ONSET AND DEATH 5 Minutes
762.5
DUE TO (b) Atelectasis - Bilateral — Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/19, 19 61, to 4/19, 19 61, that I last saw the deceased alive on 4/19, 19 61, and that death occurred at 10:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Louis G. Graff M.D. ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type) LOUIS G. GRAFF, M.D. E. Antietam St.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 4/25/61
22c. NAME OF CEMETERY OR CREMATORY: Wash. Co. Hospital
22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Louis G. Graff M.D. ADDRESS
24a. REC'D BY REGISTRAR DATE APR 28 '61
24b. REGISTRAR'S SIGNATURE Clarence L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2081375XVO

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4873

CERTIFICATE OF DEATH

04861

M

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sharpsburg
d. STREET ADDRESS: Sharpsburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

081

3. NAME OF DECEASED (Type or print): First John — Middle W — Last Holmes

4. DATE OF DEATH: Month April — Day 27 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 7 1875

9. AGE (In years lost birthday): 85 yrs.
IF UNDER 1 YEAR: Months 11 Days 20 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Henry Clay Holmes

14. MOTHER'S MAIDEN NAME: Margaret Bussard

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Betsy Holmes Sharpsburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute uremia with oliguria. — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
DUE TO (b): Arterio-sclerotic CVR disease. — 5 Yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 4 2 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute cardiac decompensation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1, ~~19~~ 1961 to 4/27/61, 19___, that (I) (we) last saw the deceased alive on 4/26/61 19__, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: W. H. Shealy M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/29/61

22c. PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22d. ADDRESS: Sharpsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 30-61

23c. NAME OF CEMETERY OR CREMATORY: Samples Manor Cemetery Near Keedysville Md.

23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Albert L. Leaf Williamsport Md

25a. REC'D BY REGISTRAR — DATE MAY 1 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4874 Items 13,14 & 23b Film G286 5/5/61 iwk 04862

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 55 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 03
d. STREET ADDRESS: 414 Garlinger Ave. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pearl Middle: Jenny Last: Kay
4. DATE OF DEATH: Month: April Day: 27, Year: 19 61
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 12, 1888
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): waitress
10b. KIND OF BUSINESS OR INDUSTRY: restaurant
11. BIRTHPLACE (State or foreign country): Ringgold, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Albert H. Grazier
14. MOTHER'S MAIDEN NAME: Mary Ellen Northcraft
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-09-7658
17. INFORMANT: Charles B. Kay, Fayetteville, Pa. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Embolus	10 minutes
420.0 DUE TO (b)	Mesenteric thrombosis	2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Arteriosclerotic heart disease	3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Senile atherosclerosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1961, to 27 April 1961, that (I) (we) last saw the deceased alive on 27 April 1961, and that death occurred at 3:05 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Ellen D Hoachlander M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/28/61
22c. PHYSICIAN'S NAME (Type): Ellen D Hoachlander
22d. ADDRESS: Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 1, 1961
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md
25a. REC'D BY REGISTRAR DATE: MAY 1 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4873 302 04863

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 138 Williams Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 03
d. STREET ADDRESS: 138 Williams Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SHERMAN Middle FRANKLIN Last KENDALL Sr

4. DATE OF DEATH: Month April Day 26 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 15 1908
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith W.M.R.R. Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Smithsburg Wash Co Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JesseJ. Kendall
14. MOTHER'S MAIDEN NAME: Amanda Kline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 705-10-4634
17. INFORMANT: Sherman F. Kendall Jr Address: 666 Highland way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Virus Infection Hagerstown Md — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
DUE TO (b): Acute Respiratory Infection 4 Days
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
480.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Alcoholism
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 2 1961 to April 26 61 that (I) (we) last saw the deceased alive on April 26 61 and that death occurred at 5:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: H. B Beachley M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov 2 61.
22c. PHYSICIAN'S NAME (Type): J. H. Beachley
22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/29/61
23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
25a. REC'D BY REGISTRAR DATE: MAY 2 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4876

CERTIFICATE OF DEATH

04864

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 129 RAY STREET

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 129 RAY STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OLIVER — Middle: BERKLEY — Last: KIBLER

4. DATE OF DEATH: Month: April — Day: 14 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 3 1897

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DISHWASHER

10b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT

11. BIRTHPLACE (County & State, or foreign country): LURAY VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: CARL KIBLER

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): UNKNOWN

16. SOCIAL SECURITY NO.: 214-09-7035

17. INFORMANT: FLORENCE A TYRE — Address: 129 RAY ST. HAGERSTOWN Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lic. hypertensive heart disease — INTERVAL BETWEEN ONSET AND DEATH: Immediate

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/11/61 19.., to 4/14/61 19.., that (I) (we) last saw the deceased alive on 4/14/61 19.., and that death occured at 2:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Ralph F Young M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4/14/61

22c. PHYSICIAN'S NAME (Type): RALPH F YOUNG MD

22d. ADDRESS: WILLIAMSPORT Md

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL — 23b. DATE THEREOF: 4/14/61 — 23c. NAME OF CEMETERY OR CREMATORY: ANATOMICAL Board of Md. — 23d. LOCATION (City, town or county) (State): BALTIMORE Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Sister Rauzer Funeral Home — ADDRESS: Hagerstown md

25a. REC'D BY REGISTRAR DATE: APR 18 '61 — 25b. REGISTRAR'S SIGNATURE: Cathryn S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4877

CERTIFICATE OF DEATH

04865

1 M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Garlock Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 341 Elizabeth Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jennie — Middle: Frances — Last: Lightner

4. DATE OF DEATH: Month: April — Day: 28 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 7, 1886

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Williamsport, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Hughes

14. MOTHER'S MAIDEN NAME: Mary Crawford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. J. W. Lightner 341 Elizabeth Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovas. Collapse — INTERVAL BETWEEN ONSET AND DEATH: Min
DUE TO (b): Arterio sclr Gen. — hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct, 19 56 to April 28, 19 61, that (I) ~~(was)~~ last saw the deceased alive on April 27, 19 61, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: Louis G. Graff M.D.
M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Louis G. Graff M.D.

22d. ADDRESS: 119 E. Antietam St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 1, 1961

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel

ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 3 61

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

Wm. G. Hook

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4878

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14866

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 24 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 44 S. CANNON AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 44 S. CANNON AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle ARTHUR — Last MARINO

4. DATE OF DEATH: Month APRIL — Day 9 — Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/5/1910

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AUTO MECHANIC

10b. KIND OF BUSINESS OR INDUSTRY: GARAGE

11. BIRTHPLACE (State or foreign country): ILLINOIS

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 199-07-2010

17. INFORMANT: MRS. DOROTHY MARINO — Address HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Three days
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Edward W. Ditto III M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 4/10/61

EXAMINER'S NAME (Type): Edward W. Ditto III, M. D. Ac

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4/11/61
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Norment — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: APR 12 '61

24b. REGISTRAR'S SIGNATURE: Anthony L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4879 — Item 2 Film G285 — 4/24/61 iwk — 04867

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ~~Boonesboro~~ Smithsburg
d. STREET ADDRESS: ~~Readers Nursing Home~~ RFD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Lewis — Middle C. — Last McClain

4. DATE OF DEATH: Month April — Day 11 — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Nov. 24, 1878

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Blue Ridge Summit Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elias McClain

14. MOTHER'S MAIDEN NAME: Mary M. Harbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-16-3414

17. INFORMANT — Address: Miss Jennette McClain Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Lateriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Acute Haemorrhage of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(c):

450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 9, 1961, to April 11, 1961, that (I) (we) last saw the deceased alive on April 10, 1961, and that death occurred at 5 A M, from the causes and on the date stated above.

22a. SIGNATURE: G. W. LeVan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/12/61

22c. PHYSICIAN'S NAME (Type): G. W. LeVan

22d. ADDRESS: Boonsboro Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-15-61
23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
23d. LOCATION (City, town, or county) (State): Smithsburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son Smithsburg, Md.

25a. REC'D BY REGISTRAR DATE: APR 17 '61
25b. REGISTRAR'S SIGNATURE: Clarence L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ... director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4880 302 04868

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1933 York Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Virginia
b. COUNTY: Morgan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berkeley Springs
d. STREET ADDRESS: Route # 2 85X-3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First LAWRENCE; Middle BAUMGARTNER; Last MICHAEL

4. DATE OF DEATH: Month April; Day 23; Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Nov 23 1896

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assessor of Morgan Co. W.Va.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Up W. Va Berkeley Springs Morgan

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James M. Michael

14. MOTHER'S MAIDEN NAME: Mary Jane Householder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: M. Michael Address: Berkeley Springs, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b): Arteriosclerosis Heart Disease
DUE TO (c): Malfunctioning Left Kidney

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 months - ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 12 1961, to April 25 1961, that (I) (we) last saw the deceased alive on April 20 1961, and that death occurred at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE: Philip J. Hirshman M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 4/26/61

22c. PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22d. ADDRESS: 159 W. Washington St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/26/61

23c. NAME OF CEMETERY OR CREMATORY: Sphors Cross Rd Cemetery

23d. LOCATION (City, town, or county) (State): near Berkeley Springs Morgan Co. W.Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 25 '61

25b. REGISTRAR'S SIGNATURE: Clinton L. Mumma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4881 — 04869

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WESTERN MD. STATE HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTO.
d. STREET ADDRESS: 1008 W. PARRE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Magdalena (LENA) Middle: Last: MICHEL

4. DATE OF DEATH: Month: 4 Day: 1 Year: 1961

5. SEX: F. — 6. COLOR OR RACE: W. — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: JUNE 1, 1867 — 9. AGE (In years last birthday): 93 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W. — 10b. KIND OF BUSINESS OR INDUSTRY: O.H. — 11. BIRTHPLACE (State or foreign country): MD. — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES MAURER — 14. MOTHER'S MAIDEN NAME: FREDERICKA — — —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Address: MR. HENRY MICHEL, 5550 LINK AVE #27.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobular Pneumonia. — 10 days
DUE TO (b): Gangrene with infection, left foot — 3 Months
DUE TO (c): Arteriosclerosis Obliterans Bilateral — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 23 1961 to April 1 1961, that (I) (~~no~~) last saw the deceased alive on April 1 1961, and that death occurred at 9.20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Young E. Chun M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: April 1, 1961

22c. PHYSICIAN'S NAME (Type): YOUNG E. CHUN — 22d. ADDRESS: 1500 Penna. Ave. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 4/5/61 — 23c. NAME OF CEMETERY OR CREMATORY: LOUDON PK. CEMTY — 23d. LOCATION (City, town, or county) (State): BALTO, MD.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: WITKE F.D. 4101 EDMONDSON AVE. — 25a. REC'D BY REGISTRAR DATE APR 5 '61 — 25b. REGISTRAR'S SIGNATURE: Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4882

CERTIFICATE OF DEATH

04870

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH a. COUNTY: ~~Md.~~ Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Smithsburg c. LENGTH OF STAY IN 1b: 60 Years	c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): X Rural, Smithsburg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Smithsburg #2	d. STREET ADDRESS: Smithsburg #2 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Mary	Middle: E. Kinsey	Last: Miller	4. DATE OF DEATH	Month: April	Day: 3	Year: 1961	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 10/23/1879	9. AGE (In years last birthday): 81 yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Duties	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Mt. Lena, Washington Co., Md. U.S.A.		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: John T. Kinsey		14. MOTHER'S MAIDEN NAME: Sophia Ambrose						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: M. Harvey Miller Jr, Smithsburg Md., #2		Address				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	7 days
DUE TO (b)	Cerebral arterio - sclerosis	5 yrs
DUE TO (c)	Generalized arterio sclerosis	12 yrs

331 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from March 27 1961, to April 3 1961, that (I) ~~(we)~~ lost saw the deceased alive on April 3 1961, and that death occurred at 6 P. M. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Walter H Wishard M.D.		4-4-61
22c. PHYSICIAN'S NAME (Type): Walter H Wishard	22d. ADDRESS: 152 Downey Waynesboro - Penna.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	4/6/61	Welty's Cemetery	Smithsburg #2, Washington Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Walter H Grove	Waynesboro Pa	APR 6 '61	Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4883 — 04871

1

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. — b. COUNTY: Wash.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Downsville c. LENGTH OF STAY IN 1b: 1½ years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 03
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Woburn Home 094	d. STREET ADDRESS: 68½ E. Franklin St. 1 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Maxwell	Middle: Matthew	Last: Monn	4. DATE OF DEATH	Month: April	Day: 29,	Year: 19 61	
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Aug. 12, 1908	9. AGE (In years last birthday): 52 yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): messenber	10b. KIND OF BUSINESS OR INDUSTRY: bank	11. BIRTHPLACE (State or foreign country): Mt. Alto, Penna.	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Matthew S. Monn	14. MOTHER'S MAIDEN NAME: Nellie Shockey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 174-01-3993	17. INFORMANT: Mrs. Thelma S. Monn	Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 420.1 — DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c): Cor-Pulmonal Obstruction of Myocardial

INTERVAL BETWEEN ONSET AND DEATH: 6 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from 4/24/61, 19___, to 4/29/61, 19___, that (I) (we) last saw the deceased alive on 4/29/61, 19___, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Ralph Young M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 4/29/61	
22c. PHYSICIAN'S NAME (Type): Ralph Young	22d. ADDRESS: Williamsport, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): burial	23b. DATE THEREOF: May 2, 1961	23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem. Cem.	23d. LOCATION (City, town, or county): Hagerstown, Md.	(State)

24. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son	ADDRESS: Hagerstown, Md.	25a. REC'D BY REGISTRAR DATE: MAY 1 '61	25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4884 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04872

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 58½ Blooms Alley
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
GEORGE	C	MONROE	April 7	1961	19

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Colored		Jany 3 1932	29 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labored	--	Millwood Clark Co Va.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Monroe	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
---	--		William C. Elliott Washington D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Esophagomalacia With Rupture Into Left Pleural Cavity. Several	Hours
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Fracture Simple, Occipital Bone Left.	4 days
DUE TO (c)	Cerebral Contusion & Laceration Intracerebral Hemorrhage.	4days

904.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c). 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)
	Fell striking head (Possibly Intoxicated.)

20c. TIME OF INJURY Hour a.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
10:50 ~~p.m.~~	4-3- 1961		Public Alley	Hagerstown,	Washington,	Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: E. W. Ditto M.D.

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county):

DATE SIGNED: 4-8-61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	4/13/61	Little Chapel Cemetery	Millwood Clark Co Va

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Andrew K. Coffman Hagerstown Md	APR 12 '61	Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4885 04873

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: Ross St. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: Elizabeth Last: Mowen

4. DATE OF DEATH: Month: 4 Day: 3 Year: 19 61

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 28, 1871

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Shank

14. MOTHER'S MAIDEN NAME: Catherine Hurtman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Nannye Loudenslager Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Dis
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Senility
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 6 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-1 19 61, to 4-3 19 61, that (I) (we) last saw the deceased alive on 3-24 1961, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): [illegible]
22d. ADDRESS: Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 4-5-61
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Fred W. Kraiss Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraiss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4886

CERTIFICATE OF DEATH

04874

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD Smithsburg

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Smithsburg

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: #2

d. STREET ADDRESS: RFD 2

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Raymond Middle: Henry Last: Myers

4. DATE OF DEATH: Month: April Day: 19 Year: 61

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: June 1, 1887

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: truck farm

11. BIRTHPLACE (State or foreign country): Ringgold, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William D. Myers

14. MOTHER'S MAIDEN NAME: Alice Reynolds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 215-36-7068

17. INFORMANT: Mrs. Helena A. Myers, Address: Smithsbur, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 Hr.

420.1

DUE TO (b): Arteriosclerotic Cardiovascular Disease — 5 Yrs.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/29 19 54, to 4/19 19 61, that (I) (we) last saw the deceased alive on 4/7 19 61, and that death occurred at 5:__ M, from the causes and on the date stated above.

22a. SIGNATURE: Charles F. Hess M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 4/20/61

22c. PHYSICIAN'S NAME (Type): Charles F. Hess M.D.

22d. ADDRESS: Smithsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 4-22-61

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery

23d. LOCATION (City, town, or county) (State): Smithsburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.

25a. REC'D BY REGISTRAR DATE: APR 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4887 04875

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 31 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Emmitsburg, 10X-3
d. STREET ADDRESS: 320 West Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma Middle: Alice Last: OHLER

4. DATE OF DEATH: Month: 4 Day: 4 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1864

9. AGE (In years last birthday): 96 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frederick Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry M. Eiler

14. MOTHER'S MAIDEN NAME: Mary Fogle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: 528 North Beaver Street — Mrs. Blanche Wilhide, York, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobular Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 17 days
DUE TO (b): gastric bleeding — 9 days
DUE TO (c): Gastric Ulcer — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5400

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 3, 1961 to April 4, 1961, that (I) (~~me~~) last saw the deceased alive on April 4, 1961, and that death occurred at 2 A M, from the causes and on the date stated above.

22a. SIGNATURE: Young E. Chun M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: April 4. 1961

22c. PHYSICIAN'S NAME (Type): YOUNG E. CHUN

22d. ADDRESS: 1500 Penna. Ave. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April, 6, 1961
23c. NAME OF CEMETERY OR CREMATORY: Keysville Cemetery
23d. LOCATION (City, town, or county) (State): Carroll County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: C. E. Wilson
ADDRESS: Emmitsburg, Md.

25a. REC'D BY REGISTRAR DATE: APR 7 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

C. E. Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04876

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 30 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 316 W. Washington St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Hagerstown
d. STREET ADDRESS: 316 W. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith — Middle: Marietta — Last: Orcutt

4. DATE OF DEATH: Month: Apr. — Day: 8 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 18, 1878

9. AGE (In years lost birthday): 83 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Locust Grove, Wash. Cty. U.S.A. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Smith

14. MOTHER'S MAIDEN NAME: Anna Gross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Hagerstown, Md.
Mrs. Bertha Bentz, 323 W. Howard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes
331X
DUE TO
(b): Hypertensive Vascular Disease — 10 years
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 10, 1961 to April 8, 1961, that (I) (we) last saw the deceased alive on April 5, 1961, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A. W. Ditto M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-10-61

22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr.

22d. ADDRESS: 215 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/12/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown, Md. Wash. Co.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 12 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

95 Years 4889 — 95 years — 04877

1. PLACE OF DEATH
a. COUNTY: Hancock Wash Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hancock Rest. Home Wash Co Hancock Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Va. — b. COUNTY: Harrison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg, W. Va.
d. STREET ADDRESS: Waldo Hotel
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First: Minnie — Middle: Byrne — Last: Pickens

4. DATE OF DEATH: Month: 4 — Day: 15 — Year: 61 (19)

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 4 1 1866 — 9. AGE (In years last birthday): 95 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Barbour Co W Va — 12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Marshall Coburn — 14. MOTHER'S MAIDEN NAME: Columbia Arnold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: E M Bearinger — Address: Hancock, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Stroke — INTERVAL BETWEEN ONSET AND DEATH: 9 days

4 20.0

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b): Arteriosclerotic Heart Disease — 20 yrs

DUE TO (c): Generalized Arteriosclerosis — 20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.): No injury

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-6 1961, to 4-13 1961, that (I) (we) last saw the deceased alive on 4-13 1961, and that death occurred at 3.15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Frank B Thomas III M. D. — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): FRANK B. THOMAS III M.D. — 22d. ADDRESS: HANCOCK, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/17/61 — 23c. NAME OF CEMETERY OR CREMATORY: Elkview Masonic — 23d. LOCATION (City, town, or county) (State): Clarksburg W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: H. L. Weaver — ADDRESS: Clarksburg — 25a. REC'D BY REGISTRAR DATE: APR 17 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4890

CERTIFICATE OF DEATH

04878

M

09

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: W. Md State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 812 Virginia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IDA — Middle: Dubel — Last: PRATT

4. DATE OF DEATH: Month: APRIL — Day: 17 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 12 1875
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: IOwn Home
11. BIRTHPLACE (State or foreign country): Wolfesville Fred Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Dubel
14. MOTHER'S MAIDEN NAME: Charlotte Renner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Alvey Rubel — Address: 108 Coffman Ave Hagerstown Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): INFARCTION OF LARGE SMALL INTESTINE — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

4500

DUE TO (b): THROMBOTIC OCCLUSION OF SUPERIOR MESETERIC — 2 DAYS

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (c): GENERALIZED ATHEROSCLEROSIS — NOT KNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

2

21. I certify that (I) (~~this hospital~~) attended the deceased from 4-14- 1961, to 4-17- 1961, that (I) (~~no~~) last saw the deceased alive on 4-17 1961, and that death occurred at 11:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: Antonio U. Pallagrosi M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 4/17/61
22c. PHYSICIAN'S NAME (Type): ANTONIO U. PALLAGROSI
22d. ADDRESS: 1500 PENNA AVE HAGERSTOWN MD

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/19/61
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
25a. REC'D BY REGISTRAR DATE: APR 20 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4891 04879

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 3 Hagerstown
d. STREET ADDRESS: 408 No Prospect St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELMER Middle ELLSWORTH Last RAILING

4. DATE OF DEATH: Month April Day 19 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 27 1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cutter Hag Shoe Co

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Md Middlesex Cunberland Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Railing

14. MOTHER'S MAIDEN NAME: Katie Ashenfelter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 214-09-5613

17. INFORMANT: Mrs Olive J. Railing Address: 408 No Prospect St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
Hagerstown Md.

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
(b): Arterio Sclerotic Heart Disease — 10 yrs
DUE TO
(c): Asthma Emphysema — Chronic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-12-61 19 to 4-19 19 61, that (I) (we) last saw the deceased alive on 4-18-61 19, and that death occurred at 7:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: J. W. Dietz M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): JNO W DIETZ
22d. ADDRESS: Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/21/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem Gardens
23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 24 '61
25b. REGISTRAR'S SIGNATURE: Clifton L. Rowe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4892 — 04880

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown, Rural
c. LENGTH OF STAY IN 1b: 29 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.F.D. # 3

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
d. STREET ADDRESS: R.F.D. #3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: GAY — Middle: CATHERINE — Last: REEL

4. **DATE OF DEATH**: Month: April — Day: 12 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: March 7, 1892

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Sharpsburg, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas H. Reel

14. MOTHER'S MAIDEN NAME: Mary C. Grice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: none

17. **INFORMANT** Address: Miss. Daisy M. Reel Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 Months
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20e. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Apr 10 19 61 to Apr 12 19 61, that (I) (~~we~~) last saw the deceased alive on 4/10 19 61, and that death occured at 5:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Walter H. Shealy M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [X] CORONER PHYS. [ ]

22b. DATE SIGNED: 4/13/61

22c. PHYSICIAN'S NAME (Type): Walter H. Shealy M.D.

22d. ADDRESS: Sharpsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/15/1961

23c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery

23d. LOCATION (City, town or county) (State): Sharpsburg, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: R. Franklin Rouzer

Suter - Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 18 '61

25b. REGISTRAR'S SIGNATURE: Dallas S. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4893 — 04881

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 21 Days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, Smithsburg
d. STREET ADDRESS: J Smithsburg #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elder — Middle: Blaine — Last: Reynolds

4. DATE OF DEATH: Month: April — Day: 6, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/20/1886

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Planning Mill

11. BIRTHPLACE (State or foreign country): Ringgold, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Reynolds

14. MOTHER'S MAIDEN NAME: Nancy Shockey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-30-7503A.

17. INFORMANT — Address: Mrs. Eva Reynolds, Smithsburg Md., #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 Wks.
DUE TO (b): Generalized Arteriosclerosis — 5 Yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 1-10 1961 to 4-6 1961, thot (I) (we) last saw the deceased alive on 4-5 1961, and that death occurred at 3:10 AM, from the couses and on the date stated above.

22a. SIGNATURE: Charles F. Hess M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-6-61

22c. PHYSICIAN'S NAME (Type): Charles F. Hess

22d. ADDRESS: Smithsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/8/61

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg

23d. LOCATION (City, town, or county) (State): Smithsburg, Washington Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Walter J. Hess — ADDRESS: Waynesboro, Pa

25a. REC'D BY REGISTRAR DATE: APR 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4894

04882

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Hagerstown
d. STREET ADDRESS: 101 Fairground Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hubert — Middle: Walter — Last: Routzahn
4. DATE OF DEATH: Month: 4 — Day: 2 — Year: 19 61

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Nov. 12, 1899
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): taxi driver
10b. KIND OF BUSINESS OR INDUSTRY: taxi
11. BIRTHPLACE (State or foreign country): Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hubert W. Routzahn Sr.
14. MOTHER'S MAIDEN NAME: Mary Alice Firestone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 214-09-7159
17. INFORMANT: Mrs. Hazel Snively — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the esophagus with metastasis — INTERVAL BETWEEN ONSET AND DEATH: Indefinite
150X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 19 19 60 to April 2 19 61 that (I) (we) last saw the deceased alive on April 2 19 61 and that death occurred at 11:27 P M, from the causes and on the date stated above.

22a. SIGNATURE: B. B. Kneisley M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/3/61
22c. PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.
22d. ADDRESS: 148 West Washington St., Hagerstown Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 4-5-61
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county): Hagerstown (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Fred W. Kraiss Hagerstown, Md.
25a. REC'D BY REGISTRAR — DATE APR 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraiss

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4895

CERTIFICATE OF DEATH

04883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR:

VR A15 (4)
15M 9/59

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 60 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARLOCK MEM. CONV. HOSPITAL	d. STREET ADDRESS 950 SUMMIT AVE. / e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CATHERINE	MALAVERY	SAUM	APRIL	4	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE		9/13/1880	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	PENNSYLVANIA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
SAMUEL F. CONRAD	FLORENCE ROBINSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	NONE	MISS ELIZABETH SAUM HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Senile Dementia	8 mos
DUE TO (b)	Generalized Arteriosclerosis	5 yrs +
DUE TO (c)		

3347

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 1 1950 to Apr 4 1961, that (I) (we) last saw the deceased alive on Apr 3 1961, and that death occurred at 5 A.M., from the causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
F F Lusby		
22c. PHYSICIAN'S NAME (Type) F F Lusby	22d. ADDRESS 230 N Potomac St	5 Apr 61

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	4/6/61	ROSE HILL CEM.	HAGERSTOWN MD.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W. T. Norment, Hagerstown Md.	APR 7 '61	Anthony S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4896

CERTIFICATE OF DEATH

04884

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 19 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 37 East Antietam St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 37 East Antietam st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIOLET Middle SAVANNA Last SCHILDTKNECHT

4. DATE OF DEATH: Month April Day 20 Year 1961

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 20 1895
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Md Balls Station Wash Co
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles C. South
14. MOTHER'S MAIDEN NAME: Lydia Gaylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Allen Schildtknecht Address: 39 E. Antietam st Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few minutes
DUE TO (b): Hypertensive C-V Disease — 2-3 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Jan 1945 to 20 Apr 1961, that (I) (~~we~~) last saw the deceased alive on 12 Apr 1961, and that death occurred at 8:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: F F Lusby M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 21 Apr 61
22c. PHYSICIAN'S NAME (Type): F F Lusby
22d. ADDRESS: 230 N Potomac

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/23/61
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md
25a. REC'D BY REGISTRAR DATE: APR 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4897 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04885

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 7 years
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Hagerstown Golf Club

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
   d. STREET ADDRESS: 515 Dual Highway
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: James — Middle: Clarence — Last: Seacrist

4. **DATE OF DEATH**: Month: April — Day: 12 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 28, 1917

9. AGE (In years last birthday): 43 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Greenskeeper

10b. KIND OF BUSINESS OR INDUSTRY: Golf Club

11. BIRTHPLACE (State or foreign country): Crown Hill W. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alanzo Seacrist

14. MOTHER'S MAIDEN NAME: Stella Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 233-07-3238

17. INFORMANT: Address: Mrs. Dorothy M. Seacrist Hagerstown, M

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushing Injury Of Chest Fractures Of Ribs 2-9, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: Instant

910.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Laceration Of Heart & Pericardium

DUE TO: Hemothorax

(c): Laceration Of Liver

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)
While bulldozing struck by swinging tree.

20c. TIME OF INJURY: Hour a.m. 10:25 — Month, Day, Year 4-12-1961

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): City Golf Course

20f. (City or town) (County) (State): Hagerstown, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4-14-61

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-16-61

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or country) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR: Scott F. Minnich & Son

ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR: DATE APR 17 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4898

CERTIFICATE OF DEATH

04886

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
c. LENGTH OF STAY IN 1b: 32 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hagerstown #5

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
d. STREET ADDRESS: Hagerstown #5
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Myrtie — Middle: Ann — Last: Shifflett

4. DATE OF DEATH: Month: April — Day: 8 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 20, 1886

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles David

14. MOTHER'S MAIDEN NAME: Jane Herring

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. W. C. Minnick, Sr. — Address: Quincy, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Generalized metastatic carcinoma	1 Mo.
DUE TO (b)	Probably from kidney	2 Mo.
DUE TO (c)	Arteriosclerotic Cardiovascular disease	10 Yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-11-60 to 4-8-61, that (I) (we) last saw the deceased alive on 4-6-61 19___, and that death occurred at 12 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Charles F. Hess M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-8-61

22c. PHYSICIAN'S NAME (Type): Charles F. Hess, M. D.

22d. ADDRESS: Smithsburg, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/11/61
23c. NAME OF CEMETERY OR CREMATORY: Ringgold
23d. LOCATION (City, town, or county) (State): Smithsburg #2, Washington, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Walter Y. Grear
ADDRESS: Waynesboro, Penna.

25a. REC'D BY REGISTRAR DATE: APR 12 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Item 20 Film 284 4-12-61 mm

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4899 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04887

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hancock
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Hancock, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock, Md.
d. STREET ADDRESS: Hancock
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wilbur — Middle: James — Last: Shives

4. DATE OF DEATH: Month: 4 — Day: 4 — Year: 19 61

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/14/1900

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Hauling

10b. KIND OF BUSINESS OR INDUSTRY: Truck Hauling

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Pete S. Shives

14. MOTHER'S MAIDEN NAME: Harriet A. Creek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-18-9551

17. INFORMANT — Address: Chester Shives, High St. Hancock, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture Of Cervical Vertebra — INTERVAL BETWEEN ONSET AND DEATH: Instant
978X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Patient jumped from top of bridge (40 feet)

20c. TIME OF INJURY — Hour: 8:50 XXX p.m. — Month, Day, Year: 4-4-61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Public highway

20f. (City or town): Hancock (County): Wash. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto M.D.

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 4-5-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/8/61

22c. NAME OF CEMETERY OR CREMATORY: Piney Plains Methodist

22d. LOCATION (City, town, or country) (State): Allegany Co., Maryland

23. FUNERAL DIRECTOR — ADDRESS: Howard F. Howe Hancock Md.

24a. REC'D BY REGISTRAR — DATE: APR 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Howe

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4900

CERTIFICATE OF DEATH

04888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

1. **PLACE OF DEATH** a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 3 yrs
   d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Homewood Church Home

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d. STREET ADDRESS: Williamsport Pike
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Anna — Middle: M. — Last: Smith

4. **DATE OF DEATH**: Month: Apr. — Day: 8 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 9, 1879

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Seemsville, Northampton Cty., Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Israel Remaley

14. MOTHER'S MAIDEN NAME: Matilda Donner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —— (If yes, give war or dates of service): ——

16. SOCIAL SECURITY NO.: ——

17. **INFORMANT** Address: Mrs. Mark Wagner, Homewood Church Home Williamsport Pike, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 522 Cardio vascular Collapse
DUE TO (b): Congestive failure
DUE TO (c): Hypostatic pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Ann Dys Dys

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psycho-neurotic - Insanity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from [illegible] 19[illegible], to 4/8 19 61, that (I) (we) last saw the deceased alive on 4/7 19 61, and that death occurred at [illegible] M, from the causes and on the date stated above.

22a. SIGNATURE: Louis G. Huff M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/8/61

22c. PHYSICIAN'S NAME (Type): Louis G. Huff

22d. ADDRESS: 114 E. Antrim St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/12/61

23c. NAME OF CEMETERY OR CREMATORY: St. Peter's Church Cem

23d. LOCATION (City, town, or county) (State): Seemsville, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 12 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Travis

VR A1S (4)
15M 9/59

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4901 (0486)

M

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport X
d. STREET ADDRESS: 17 Frederick Street 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

091

3. NAME OF DECEASED (Type or print): First Rosie Middle Belle Last SMITH
4. DATE OF DEATH: Month 4 Day 24 Year 1961

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 15 1879
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months 0 Days 8
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: Homes
11. BIRTHPLACE (State or foreign country): Williamsport Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Nelson Smith
14. MOTHER'S MAIDEN NAME: Rosie (Unknown)

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Family Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobular Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: One Week
DUE TO (b): Diabetes Mellitus — 7 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease, Infection of legs
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 29, 1961, to April 24, 1961, that (I) ~~(no)~~ last saw the deceased alive on April 24, 1961, and that death occurred at 11:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Young E Chun M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: April 25, 1961
22c. PHYSICIAN'S NAME (Type): YOUNG E. CHUN
22d. ADDRESS: 1500 Penna Ave, Hagerstown, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 28-61
23c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
23d. LOCATION (City, town, or county) (State): Williamsport Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L Kopf ADDRESS: Williamsport, Md
25a. REC'D BY REGISTRAR DATE: APR 27 '61
25b. REGISTRAR'S SIGNATURE: Cletus S. Kinna

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4902

CERTIFICATE OF DEATH

04890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Washingtin — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg R # 1
c. LENGTH OF STAY IN 1b: 18 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: near Cavetown

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg R # 1
d. STREET ADDRESS: near Cavetown
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ARTHUR — Middle LEE — Last SPRECHER

4. DATE OF DEATH: Month April — Day 25 — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: March 33 1885

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Williamsport Wash Co Md

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Martin Sprecher

14. MOTHER'S MAIDEN NAME: Missouri Stahl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 216-22-8216

17. INFORMANT: Mrs Louise Pittenger Address R # 1 Smithsburg Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 25 mnts.
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Arterio Sclerosis Generalized — 7 yrs

332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 1 19 60 to April 25 19 61 that (I) (we) last saw the deceased alive on April 25 19 61 and that death occurred at 8 A M, from the causes and on the date stated above.

22a. SIGNATURE: G. A. Kohler M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: April 27 1961

22c. PHYSICIAN'S NAME (Type): G. A. KOHLER

22d. ADDRESS: Smithsburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/28/61

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery

23d. LOCATION (City, town, or county) (State): Smithsburg Wash Co Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md

25a. REC'D BY REGISTRAR DATE: MAY 2 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4903

CERTIFICATE OF DEATH

302 0489

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 53 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 938 Spruce St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 938 Spruce St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAVID Middle CLYDE Last STOUFFER

4. DATE OF DEATH: Month April Day 11 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 12 1882

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tin Smith

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Cavetown Wash Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Stouffer

14. MOTHER'S MAIDEN NAME: Lillie Sigler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Vera G. Stouffer Address: 938 Spruce St Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Glomer. Nephritis — INTERVAL BETWEEN ONSET AND DEATH: April 1-61

590X

DUE TO: ~~DUE TO~~

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arterio-sclerotic Heart Disease — DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 18 1961 to April 11 1961, that (I) (we) last saw the deceased alive on April 11 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Sidney Noverstein M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-11-61

22c. PHYSICIAN'S NAME (Type): SIDNEY NOVERSTEIN

22d. ADDRESS: FUNKSTOWN MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/13/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 14 '61

25b. REGISTRAR'S SIGNATURE: Carlton L. Kroh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4904 Reg. Dist. No. 04892

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Hagerstown
c. LENGTH OF STAY IN 1b: -
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route # 81

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Hardy
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Milgap
d. STREET ADDRESS: -- 85X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JENNINGS Middle LEE Last STRAWDERMAN

4. DATE OF DEATH: Month Apr. Day 16 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 5, 1927

9. AGE (In years last birthday): 34 yrs.

IF UNDER 1 YEAR: Months ___ Days ___

IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mathias, Hardy Co., W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert S. Strawderman

14. MOTHER'S MAIDEN NAME: Mamie Mathias

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Dellinger Funeral Home, Woodstock, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ~~Compound fractures~~ of skull with one quarter of — INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): skull and face torn away. Multiple comminuted

DUE TO (c): fractures of right leg and left leg.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Tractor missed overhead bridge landing on railroad then hit by oncoming train.

20c. TIME OF INJURY: Hour 4:00 a.m. p.m. Month, Day, Year 4-16-61

20d. INJURY OCCURRED While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Fed. Route #81

20f. (City or town) Hagerstown (County) Washington (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. W. Ditto M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. E.W. Ditto, Jr.

DATE SIGNED: 4/16/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/18/61

22c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemtery

22d. LOCATION (City, town, or county) (State): Lost River, Hardy Co., W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: APR 18 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Nuss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4905

04893

1

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Wash.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown c. LENGTH OF STAY IN 1b: 45 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital	d. STREET ADDRESS: 325 N. Locust St., — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Raymond	Middle: James	Last: STRAWSBURG	4. DATE OF DEATH	Month: 4	Day: 27 — Year: 1961
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Jan. 1, 1890	9. AGE (In years last birthday): 71 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): general work	10b. KIND OF BUSINESS OR INDUSTRY: awning mfg.	11. BIRTHPLACE (State or foreign country): Carroll County, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph J. Strawsburg		14. MOTHER'S MAIDEN NAME: Mary Whitelether	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 214-09-0371	17. INFORMANT: Mrs. George Pappas, Hagerstown, Md. (Address)	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 7 months

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

157X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 20, 1961, to April 27, 1961, that (I) ~~(we)~~ last saw the deceased alive on April 27, 1961, and that death occurred at P. M., from the causes and on the date stated above.

22a. SIGNATURE: Young E. Chun M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑	22b. DATE SIGNED: April 29, 1961	1:05
22c. PHYSICIAN'S NAME (Type): YOUNG E. CHUN	22d. ADDRESS: 1500 penna. Ave. Hagerstown, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): burial	23b. DATE THEREOF: Apr. 30, 61	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d. LOCATION (City, town, or county) (State): Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE: MAY 1 '61	25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus	

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4906 04894

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 617 N. Prospect St.,

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. b. COUNTY: Wash.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 03
   d. STREET ADDRESS: 617 N. Prospect 1
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lester Middle: W Last: Strosnider

4. DATE OF DEATH: Month: 4 Day: 25 Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 11, 1908

9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Yard Man

10b. KIND OF BUSINESS OR INDUSTRY: Jamison Cold Storage

11. BIRTHPLACE (State or foreign country): Strausburg, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 228-30-5492

17. INFORMANT: Mrs. Alice K. Strosnider Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b): Atherosclerosis — Recent

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Fred W. Kraiss M.D.

EXAMINER'S NAME (Type): FRED W. KRAISS

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 4/26/61

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 4-28-61

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or country) (State): Hagerstown Md.

23. FUNERAL DIRECTOR: Fred W. Kraiss ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR: APR 28 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4907 — 04895

1

M

X

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Funkstown
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 31 Frederick Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Funkstown 03
d. STREET ADDRESS: 31 Frederick Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nora — Middle: Agnes — Last: Sweeney

4. DATE OF DEATH: Month: April — Day: 9 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 16 1894

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months: 5 — Days: 23
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner Restaurant

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (County & State, or foreign country): Antietam Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: George W. Otzelberger

14. MOTHER'S MAIDEN NAME: Catherine Gift

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 219-20-1219

17. INFORMANT: Mr. Victor H. Sweeney — Address: 31 Frederick Road Funkstown Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): coronary ateriosclerosis. — 1 year
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 1, 19 61, to Apr. 9, 19 61, that (I) (we) last saw the deceased alive on 4/7/61 19 , and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Walter H. Shealy M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/11/61
22c. PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.
22d. ADDRESS: Sharpsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 12-61
23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
23d. LOCATION (City, town or county) (State): Sharpsburg Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf
ADDRESS: Williamsport, Md

25a. REC'D BY REGISTRAR DATE: APR 13 '61
25b. REGISTRAR'S SIGNATURE: Curtis S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4903 04896

1. **PLACE OF DEATH**
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 48 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 238 FREDERICK ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First MARY Middle LEOTA Last TROVINGER

4. **DATE OF DEATH**: Month APRIL Day 20 Year 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/13/1904

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELIJAH BAKER

14. MOTHER'S MAIDEN NAME: FANNIE EYLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 217-30-6168

17. **INFORMANT**: MR. RAYMOND T. TROVINGER Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cachexia	1 week
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Carcinomatosis	5 months
DUE TO (c)	Carcinoma of ovary	5 months

175.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-18-61, 19__, to 4-20-61, 19__, that (I) (we) last saw the deceased alive on 4-20-61, 19__, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Paul Harrison M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-22-61

22c. PHYSICIAN'S NAME (Type): Paul Harrison, M. D.

22d. ADDRESS: 318 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/23/61

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.

23d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. J. Norment, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4909 — 04897

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 (M) (I) 081 0 1 1 8

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residance before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 661 Forrest Drive
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MERLE — Middle RICHARD — Last VAUGHN III

4. DATE OF DEATH: Month April — Day 13 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 13, 1961

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days 1 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Merle Vaughn

14. MOTHER'S MAIDEN NAME: Jeanette Polley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Merle Vaughn — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis —
DUE TO: Premature Birth 7 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

762.5

INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 13, 1961 to April 13 1961, that (I) (we) last saw the deceased alive on April 13 1961, and that death occured at 3:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip J. Hirshman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/14/61

22c. PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22d. ADDRESS: 159 W. Washington St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/14/1961

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: P. Franklin Rouzer

ADDRESS: Suter - Rouzer Funeral Home Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE APR 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

208122.2.XVI

M

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4910

CERTIFICATE OF DEATH

303

04898

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown — c. LENGTH OF STAY IN 1b: 4 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital	d. STREET ADDRESS: 1437 West Antietam St — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
LUTHER	MAC	WALLECH	April 9	1961	19

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		April 1 1908	53 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Equipment Operator	County Roads Dept	Greencastle Franklin Co Pa	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Wallech	Susie Cordell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No --	195-16-3941	Mrs Florence S. Wallech 437 W. Antietam Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO (b) Multiple coronary artery occlusion — 11 weeks

DUE TO (c) Coronary artery arteriosclerosis — years

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic bronchitis and emphysema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Mar 19 59, to Apr 9 1961, that (I) (we) last saw the deceased alive on Apr 8 19 61, and that death occurred at 8 A M, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
John C. Stauffer			

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
John C. Stauffer 145 So Prospect St	Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	4/12/61	Cedar Lawn Mem Gardens	Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Andrew K. Coffman Hagerstown Md.	APR 14 '61	Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4911 04899

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hancock
c. LENGTH OF STAY IN 1b: 50 Years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Home Rural Hancock

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hancock
d. STREET ADDRESS: Rural Hancock
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Olive — Middle May — Last Weller

4. DATE OF DEATH: Month 4 — Day 16 — Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/21/05

9. AGE (In years last birthday): 56 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months — Days — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Fulton Co., Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Mellott

14. MOTHER'S MAIDEN NAME: Margaret Keefer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Howard J. Weller — Address: Rural 2 Hancock, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Diabetes
DUE TO (c): Varicose ulcerous

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr 16 19 61 to Apr 16 19 61, that (I) (we) last saw the deceased alive on Apr 16 19 61 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: L M Shaffer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): L. M. SHAFFER

22d. ADDRESS: HANCOCK Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/18/61

23c. NAME OF CEMETERY OR CREMATORY: Orchard Ridge

23d. LOCATION (City, town, or county) (State): Washington Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Howard J. Heine — ADDRESS: Hancock md

25a. REC'D BY REGISTRAR DATE: APR 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4912

CERTIFICATE OF DEATH

04950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
c. LENGTH OF STAY IN 1b: 25yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 331 N. Jonathan Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland.
d. STREET ADDRESS: 331 N. Jonathan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bryant — Middle: (no) — Last: William

4. DATE OF DEATH: Month: April — Day: 23 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 7-12-1906

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Letterkenny depot

11. BIRTHPLACE (State or foreign country): Marion, S.C.

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: John William

14. MOTHER'S MAIDEN NAME: Eugunia Hanies

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hazel Adams — Address: 116 W. Bethel Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronoma - Esophagus — INTERVAL BETWEEN ONSET AND DEATH: 1yr.
DUE TO
150X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/22 1960, to April 23 1961, that (I) (we) last saw the deceased alive on April 23 1961, and that death occurred at 5P M, from the causes and on the date stated above.

22a. SIGNATURE: Philip J. Hirshman M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/26/61

22c. PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22d. ADDRESS: 159 W. Washington St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 1 1961

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John R Watson Jr — ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: MAY 2. '61

25b. REGISTRAR'S SIGNATURE: Clinton S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4913 — 04901

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Hagerstown R#5
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Hagerstown R#5

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
e. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hagerstown R#5
d. STREET ADDRESS: 1 Hagerstown R#5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Elizabeth — Last: Williams

4. DATE OF DEATH: Month: April — Day: 18 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 7, 1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Washington Co. Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Hartman

14. MOTHER'S MAIDEN NAME: Sarah Warfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: F. E. Williams Hagerstown, Md. R#5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Oct. 1946
332X
DUE TO (b): Arteri-sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerotic Heart D.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: — a.m. p.m. — Month, Day, Year: — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 15, 1960 to April 18, 1961, that (I) (we) last saw the deceased alive on April 18 1961, and that death occured at 6 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Sidney Hoverstein M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-19-61

22c. PHYSICIAN'S NAME (Type): SIDNEY HOVERSTEIN

22d. ADDRESS: FUNKSTOWN MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/21/61

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel

ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 20 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

Wm. G. Horst

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4914

CERTIFICATE OF DEATH

04902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 55 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 118 Alexander St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
   d. STREET ADDRESS: 118 Alexander St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Humer — Middle: Ola — Last: Williamson

4. **DATE OF DEATH**: Month: April — Day: 19 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 30, 1886

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months: — Days: —

IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Locomotive Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): Bentonville, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Caleb Leonard Williamson

14. MOTHER'S MAIDEN NAME: Sarah Frances Bolten

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 719-05-7102

17. INFORMANT: Mrs. H. O. Williamson — Address: 118 Alexander St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years

4200

DUE TO (b): Generalized Arteriosclerosis. — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 5, 19 58 to Apr. 19, 19 61 that (I) (we) last saw the deceased alive on Apr. 16, 19 61, and that death occured at 7A M, from the causes and on the date stated above.

22a. SIGNATURE: R. A. Bell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Apr. 20, 1961.

22c. PHYSICIAN'S NAME (Type): R. A. Bell, M. D.

22d. ADDRESS: Hagerstown, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/22/61

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county): Hagerstown (State): Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel

ADDRESS: Hagerstown, Md.

Wm. G. Arnold

25a. RECEIVED BY REGISTRAR DATE: APR 24 61

25b. REGISTRAR'S SIGNATURE: Grace S. Frantz

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4915 302 04903

M

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 19 Yrs
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: 59 West Side Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): 03 Hagerstown
d. STREET ADDRESS: 59 West Side Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle HENRY Last WILSON Jr

4. DATE OF DEATH: Month April Day 5 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 6 1887

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Lanocoaning Garrett Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

I

13. FATHER'S NAME: William Wilson

14. MOTHER'S MAIDEN NAME: Sarah Jane Pooley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 214-09-7850

17. INFORMANT: Mrs Viola S. Wilson Address: 59 West Side Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).] Hagerstown Md.

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immed.
DUE TO
420.1
Conditions, if ony, which gave rise to immediate cause (o), stoting the underlying couse lost.
(b) General arteriosclerosis and — 10 yrs
DUE TO
(c) Coronary atherosclerosis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Prostate hypertrophy, benign

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Haur a. m. p. m. Month, Day, Yeor 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/30/60 19___ to 4/5/61 19___, that (I) (we) last saw the deceased alive on 3/29/61 19___, and that death occurred at 9:35 M, from the causes and on the date stated above.

22a. SIGNATURE: Edward W. Ditto III, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/5/61

22c. PHYSICIAN'S NAME (Type): Edward W. Ditto 111, M. D.

22d. ADDRESS: 217 West Washington Street

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/8/61
23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4916

Reg. Dist. No. 04004

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Memorial Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 938 Mulberry Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Wingert

4. DATE OF DEATH: Month: April — Day: 1, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/15/1879

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Greenwood, Franklin Co.,

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Tilman Talbert

14. MOTHER'S MAIDEN NAME: Roseanna Bohn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: John D. Wingert, 325 Fairview Ave., Waynesboro Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Acute Coronary Insufficiency 420.0	1 week
DUE TO (c)	Arteriosclerotic Heart Disease	10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1950, 19____, to 4/1/61, 19____, that I last saw the deceased alive on 3/30/61, 19____, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Earl Young M.D. — ADDRESS (Street, city or town, state): 148 N. Potomac St. — DATE SIGNED: 4/3/61

PHYSICIAN'S NAME (Type): S. EARL YOUNG M.D. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/4/61
22c. NAME OF CEMETERY OR CREMATORY: Green Hill
22d. LOCATION (City, town, or county) (State): Waynesboro, Franklin Co., Pa.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Walter Y. Stover, Waynesboro Pa

24a. REC'D BY REGISTRAR — DATE: APR 5 '61

24b. REGISTRAR'S SIGNATURE: Clifford L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4917 04905

M

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL
d. STREET ADDRESS: KEEDYSVILLE MD. R.1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First INFANT Middle WYAND Last
4. DATE OF DEATH: Month APRIL Day 19 Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: APRIL 18 1961
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months Days ONE
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): HAGERSTOWN WASH. Co. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: DAVID WYAND
14. MOTHER'S MAIDEN NAME: KATHLEEN HUFFER

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: DAVID WYAND Address: KEEDYSVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO (b): Congenital Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7545

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-18- 1961, to 4-19- 1961, that (I) (we) last saw the deceased alive on 4-19- 1961, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Joseph Secondari, M. D.
22d. ADDRESS: 21 North Main St. Boonsboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: APR. 21. 1961
23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEMETERY
23d. LOCATION (City, town, or county) (State): KEEDYSVILLE MD. R.1

24. FUNERAL DIRECTOR'S SIGNATURE: John N. Bast ADDRESS: BOONSBORO MD
25a. REC'D BY REGISTRAR DATE: APR 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2081202 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4918 Item 12 File G266 5/1/61 1wk 04906

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
d. STREET ADDRESS 1001 Security Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Rudolph Middle --- Last Yonger
4. DATE OF DEATH Month April Day 20 Year 1961

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH December 10, 1891
9. AGE (In years lost birthday) 69 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance
10b. KIND OF BUSINESS OR INDUSTRY Cement Corp.
11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Johan Yonger
14. MOTHER'S MAIDEN NAME Anna Decker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-10-6889
17. INFORMANT Miss Anna Yonger Address Hagerstown, md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hr
DUE TO (b) Hypertension — 3-4yr
DUE TO (c)

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/17/61 19__ to 4/20/61 19__, that (I) (we) last saw the deceased alive on 4/20 1961, and that death occurred at 4:35a from the causes and on the date stated above.

22a. SIGNATURE Robert V. h. Campbell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Robert V. h. Campbell
22d. ADDRESS 145 W Washington ST Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 4-22-61
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State) Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE APR 24 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed to the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4919 — 04907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 44 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 622 N. Prospect St.

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 622 N. Prospect St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Charles — Middle: Edward — Last: Zepp

4. **DATE OF DEATH**: Month: April — Day: 5 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 21, 1891

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car man

10b. KIND OF BUSINESS OR INDUSTRY: Rail Road

11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Zepp

14. MOTHER'S MAIDEN NAME: Elizabeth Bowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 705-10-8625

17. **INFORMANT**: Mrs. C. E. Zepp — Address: 622 N. Prospect St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction. — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO (b): Atherosclerotic Heart Disease — Several years.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 24, 1961 to Apr. 5, 1961, that (I) (we) last saw the deceased alive on April 4, 1961, and that death occured at 3A.M, from the causes and on the date stated above.

22a. SIGNATURE: R. A. Bell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Apr. 5, 1961.

22c. PHYSICIAN'S NAME (Type): R. A. Bell, M.D.

22d. ADDRESS: Hagerstown, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 7, 1961

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Wm. A. Hamst